our heartfelt condolences to the family and to the State of Strom Thurmond. In many respects, he was a legend. Many of us had the good fortune to serve with him as a Senator. He was a Governor, a Presidential candidate, a soldier, a father, a citizen. In many respects, he fought, lived, contributed, and legislated in a way that will be written about and commented on for years and decades to come.

Much more will be said, but I think as we consider his contribution tonight we can say, as we consider the opportunity that we had to serve with him, Republicans and Democrats, that it was our privilege to do so.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. HOLLINGS. Mr. President, my friend and colleague of 36 years in the Senate is gone. A giant oak in the forest of public service has fallen.

I started with Senator Thurmond as a young law student in 1946 when he first ran for Governor and have been more or less with him over these many, many years. I will have a real recount of our work together later. That is the way it was even though we ended up on other sides of the aisle. There was never any doubt about the interests of South Carolina.

We have all this argument going on now with respect, for example, to judges. He and I got together very early. We agreed when his President was in office from his particular party that he had the appointment, but he always asked me about it and, of course, I in turn asked him about it. We checked with each other. That is the kind of way we worked together over the some 36 years.

I can say just a living legend of South Carolina now has been terminated. But I want to give Nancy and the children my heartfelt condolences. Peatsy and I have known them and been with them over the many, many years. I will have more to say at a later time. I thank the leadership for their recognition. I hope, perhaps, when we complete our work tonight, we might adjourn out of respect for our colleague.

Mr. FRIST. Why don't we take just a moment of silence in honor of Strom Thurmond.

(Moment of Silence.)

Mr. FRIST. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 1132

Mr. SANTORUM. Mr. President, I call up amendment No. 1132 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SANTORUM] proposes an amendment numbered 1132.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow eligible beneficiaries in MedicareAdvantage plans to elect zero premium, stop-loss drug coverage protection)

On page 343, between lines 15 and 16, insert the following:

''(f) ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR ELIGIBLE BENEFICIARIES ENROLLED IN MEDICAREADVANTAGE PLANS.—

''(1) IN GENERAL.—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, the plan makes available such coverage with the following modifications:

''(A) NO PREMIUM.—Notwithstanding subsection (d) or sections 1860D–13(e)(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage shall be zero.

''(B) BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

''(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

''(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection, '$5000.00' shall be substituted for '$3,700' in subparagraph (B)(i)(I) of such subsection.

''(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

''(C) APPLICATION OF LOW-INCOME SUBSIDIES.—Notwithstanding subsection (f) or section 1860D–19, the Administrator shall not apply the following provisions of subsection (a) of such section:

''(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

''(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

''(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

''(2) PENALTY FOR ENROLLING IN A ZERO PREMIUM STOP-LOSS PROTECTION PLANS AFTER INITIAL ELIGIBILITY FOR SUCH ENROLLMENT.—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D–2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

''(3) PROCEDURES.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

''(4) NO EFFECT ON MEDICARE DRUG PLANS.—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug plan or under a contract under section 1860D–13(e).''

Mr. SANTORUM. Mr. President, one of the key components that many Members on this side of the aisle would like to see accomplished is to draw as many people as possible into the competitive model set up in this bill. We believe it is the more efficient, higher quality delivery of health care services, the Medicare Advantage plan.

Unfortunately, through negotiations, a lot of the incentives the President has to encourage people to get into those plans and thereby make them work have been taken out in the current version on the floor. That is to the great consternation, I know, of the White House and many Members on this side of the aisle.

For quite some time I have been trying to think how they can create incentives—carrots, if you will, as opposed to sticks—to encourage people to get into these kinds of plans. Originally, I intended to offer a differential benefit—in other words, a benefit that would have what I call a standard benefit in the fee-for-service option and an enhanced benefit in the Medicare Advantage option. I was fairly convinced, in discussing with the people on my side of the aisle, we probably would not have a chance to succeed; that there were people who had made commitments that a differential benefit was not something for this time.

I went about trying to figure out, could we create incentives to people to come into Medicare Advantage, which I believe is the future of Medicare and the best way to run the system without creating a differential benefit. The amendment before the Senate does that. The amendment before the Senate creates an option for beneficiaries who participate in Medicare Advantage. It is a pharmaceutical option. Instead of just having no pharmaceutical benefit, which you could if you do not get into the Medicare Advantage Program, we have the standard benefit which is required if you participate in the PPOs, HMOs, and POSs that will be created here.

What I will do with this amendment is create another option for seniors who select Medicare Advantage. That option would be a zero premium catastrophic benefit. So you could choose between the standard benefit, the $35 premium, and the 50 percent copay, and the donut hole, and all the things described over and over again, or if you did not want to pay a premium but wanted some catastrophic coverage,

wanted some benefit, no premium, no cost, you could join this.

The CBO scored this as attracting twice as many people into the PPOs and HMOs as the underlying bill. It would make those plans much more desirable for beneficiaries. I believe that should be one of the goals of this legislation, to make the new and improved and stronger plan a more robust plan.

Unfortunately, according to the Congressional Budget Office, when people move from the fee-for-service plan into the Medicare Advantage plan, the Congressional Budget Office assumes those plans will be more expensive. And because they will be more expensive, this amendment costs money. It doubles the participation but costs $20, to $25 billion, which is the back of the envelope. And God bless the CBO; that is the best they could do at this late hour.

I firmly believe this is a reasonable compromise between those who would not want to have the differential benefit and those who would because it is unfair to the fee-for-service participants and those who believe we need to have an incentive for people to get into the Medicare Advantage Program. This strikes the compromise. This is where we could go.

There are all sorts of things we have done to eliminate adverse selection and all the other problems inherent in offering two different benefits. We believe we actually address the vast majority of those problems in this amendment. Nevertheless, we have run into the roadblock that this bill has run into the entire time when it comes to the competitive model and CBO and their estimation of costs.

For the record, the White House does not see it that way. The White House sees the competitive model as saving money. Under their scoring, this would probably actually save money and move people into a higher quality, more efficient system.

AMENDMENT NO. 1132 WITHDRAWN

As a result of the fact of the score which is $20 to $25 billion, and we do not have that, I am going to withdraw my amendment and hope this idea which I believe is in the center here is a compromise between two competing ideas of how to structure this bill.

It will be considered in conference as a way of trying to bring the two sides together in something that does not disadvantage the fee-for-service plan but creates an opportunity for incentives to go to the Medicare Advantage plan.

Mr. President, with that I ask unanimous consent to withdraw my amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The Senator from Oklahoma.

Mr. NICKLES. I compliment my colleague from Pennsylvania. Especially this late at night, when a lot of us are thinking about our departed friend and colleague, Senator Thurmond, I appreciate his withdrawing this amendment.

For the information of our colleagues, I think we are very close to finishing this bill. We may have one or two rollcall votes. I think we are just about ready to vote on the Feinstein-Chafee amendment and possibly one other amendment, and I think we are very close to be able to vote on final passage, for the information of our colleagues.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1060

Mr. KENNEDY. Mr. President, I will just take a moment to address the amendment of the Senator from California, Mrs. FEINSTEIN, and her colleagues, in terms of means testing the Medicare system. That is what we would be doing, changing what is effectively an insurance system into a welfare system. There is, really, no question about that.

The fact is, the Part B of the Medicare system is basically a progressive system as it is at the present time. Wealthy people are paying a great deal more into that system than they are taking out.

My concern is, if this passes, it is only a question of time before the healthiest individuals who can qualify under the Part B premium are going to leave the Medicare system and it is going to deteriorate into a general welfare system. The kind of Medicare system seniors relied on, day in and day out, would be destroyed. Make no mistake about it.

That is why the AARP is strongly opposed to it, as well as the National Committee to Preserve Social Security.

I hope this amendment is not accepted. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 990, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that amendment No. 990, previously adopted, be modified with language I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

At the end of subtitle A of title II, add the following:

SEC. ___. IMPROVEMENTS IN MEDICARE-ADVANTAGE BENCHMARK DETERMINATIONS.

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICAREADVANTAGE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(B) by adding at the end the following new subparagraph:

''(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

AMENDMENT NO. 960, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Senator DAYTON's amendment, No. 960, be modified with the modification that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require a streamlining of the medicare regulations)

At the end of subtitle A of title V, add the following:

SEC. ___. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'') to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (b)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its infeasibility. He shall then establish a possible reduction to be achieved by January 1, 2005.

VITIATION OF VOTE ON AMENDMENT NO. 1041

Mr. GRASSLEY. Mr. President, I ask unanimous consent to vitiate the vote by which amendment No. 1040 was adopted.

Mr. BAUCUS. Amendment No. 1041.

Mr. GRASSLEY. I am sorry, No. 1041.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1096

Mr. GRASSLEY. I ask unanimous consent that the pending amendment be temporarily set aside, amendment No. 1096 be called up, adopted, and the motion to reconsider be laid on the table.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment (No. 1096) was agreed to, as follows:

(Purpose: To require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project)

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms ''hospital'' and ''critical access hospital'' have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

AMENDMENT NO. 989, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Collins amendment, amendment No. 989, be modified with modifications that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To increase medicare payments for home health services furnished in a rural area)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. ___. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

''(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

''(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).''.

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following: ''Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

AMENDMENTS NOS. 1122, 1074, 1023, 1114, 1115, 1045, 1058, 1117, 1044, 1056, 996, 1013, 1121, 989, AS MODIFIED, 1126, 996, 1118, 1085, 1017, 968, 948, 960 AS MODIFIED, 1054, AND 1030

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1122, Brownback; No. 1074, Coleman; No. 1023, Collins; No. 1114, Kyl; No. 1115, Kyl; No. 1045, Chambliss; No. 1058, Craig; No. 1117, Baucus; No. 1044, Bayh; No. 1056, Shelby; No. 996, Reed of Rhode Island; Bond amendment No. 1013; Kyl, No. 1128; Collins, No. 989, as modified; Dole, No. 1126, with Edwards added as a cosponsor; Reed of Rhode Island, No. 996; Specter, No. 1118; Specter, No. 1085.

The PRESIDENT pro tempore. Is there objection?

Mr. BAUCUS. Mr. President, this side agrees.

The PRESIDENT pro tempore. Is there objection?

If not, the amendments will be considered en bloc.

The amendments are as follows:

(Amendments Nos. 1122 and 1117 are printed in today's RECORD under ''Text of Amendments.'')

(Amendments Nos. 1017, 968, 948, 1054 and 1030 are printed in a previous edition of the RECORD.)

AMENDMENT NO. 1074

(Purpose: To amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology)

At the end of subtitle C of title IV, add the following:

SEC. ___. IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting ''consistent with subsection (j)'' after ''the Secretary shall ensure''; and

(B) by adding at the end the following new subsection:

''(j) NATIONAL COVERAGE DETERMINATION PROCESS.—

''(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

''(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

''(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

''(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

''(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

''(B) provide a 30-day period for public comment on such draft;

''(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

''(D) include in such final decision summaries of the public comments received and responses thereto;

''(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

''(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

''(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term 'national coverage determination' has the meaning given such term in section 1869(f)(1)(B).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

AMENDMENT NO. 1023

(Purpose: To provide for the establishment of a demonstration project to clarify the definition of homebound)

At the appropriate place in subtitle B of title IV, insert the following:

SEC. ___. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

AMENDMENT NO. 1114

(Purpose: To require the GAO to study the impact of price controls on pharmaceuticals)

At the appropriate place, insert the following:

SEC. . GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATENT PROTECTIONS IN THE G–7 COUNTRIES.

(A) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance;

(2) The proportion of the costs for innovation borne by American consumers, compared with consumers in the other six countries;

(3) A review of how closely the observed prices in regulated markets correspond to the prices that efficiently distribute common costs of production (''Ramsey prices'');

(4) A review of any peer-reviewed literature that might show the health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health;

(5) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States;

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm caused to consumers in markets without price regulations may be remedied;

(7) In parallel trade regimes, how much of the price difference between countries in the European Union is captured by middlemen and how much goes to benefit patients and health systems where parallel importing is significant; and

(8) How much cost is imposed on the owner of a property right from counterfeiting and from international violation of intellectual property rights for prescription medicines.

(B) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (A).

AMENDMENT NO. 1115

(Purpose: To express the sense of the Senate concerning Medicare payments to physicians and other health professionals)

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.4 percent cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991–2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation as measured by Medicare's own conservative estimates.

(4) The sustainable growth rate (SGR) expenditure target, which is the basis for the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

AMENDMENT NO. 1045

(Purpose: To provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services)

At the end of subtitle B of title IV, add the following:

SEC. ___. DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—The Secretary shall create additional groups of covered

OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium–103 and iodine–125 devices.

(c) DURATION.—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

AMENDMENT NO. 1058

(Purpose: To restore the Federal Hospital Insurance Trust Fund to the financial position it would have been in if a clerical bookkeeping error had not occurred)

At the appropriate place in title VI, insert the following:

SEC. ___. RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term ''clerical error'' means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) TRUST FUND.—The term ''Trust Fund'' means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

AMENDMENT NO. 1044

(Purpose: To adjust the urban health provider payment)

At the appropriate place, insert the following:

SEC. ___. URBAN HEALTH PROVIDER ADJUSTMENT.

(a) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r–4(f)).

(b) HOSPITAL DESCRIBED.—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) LIMITATION.—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(1)(A)).

AMENDMENT NO. 1056

(Purpose: To prevent the Secretary of Health and Human Services from modifying the treatment of certain long-term care hospitals as subsection (d) hospitals)

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting '', and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)'' before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

AMENDMENT NO. 1013

(Purpose: To ensure that patients are receiving safe and accurate dosages of compounded drugs)

At the appropriate place, insert the following:

SEC. ___. COMMITTEE ON DRUG COMPOUNDING.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the ''Committee'') within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) MEMBERSHIP.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report concerning the recommendations of the Committee to improve and protect patient safety.

(d) TERMINATION.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

AMENDMENT NO. 1121

(Purpose: To express the sense of the Senate concerning the structure of Medicare reform and the prescription drug benefit to ensure Medicare's long-term solvency and high quality of care)

At the appropriate place, insert the following:

SEC. . SENSE OF THE SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) FINDINGS.—The Senate makes the following findings:

(1) America's seniors deserve a fiscally-strong Medicare system that fulfills its promise to them and future retirees.

(2) The impending retirement of the ''baby boom'' generation will dramatically increase the costs of providing Medicare benefits. Medicare costs will double relative to the size of the economy from 2 percent of GDP today to 4 percent in 2025 and double again to 8 percent of GDP in 2075. This growth will accelerate substantially when Congress adds a necessary prescription drug benefit.

(3) Medicare's current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease management programs, and host of other advances. Reforming Medicare to create a more self-adjusting, innovative structure is essential to improve Medicare's efficiency and the quality of the medical care it provides.

(4) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of America's seniors, not the government, and would create a powerful incentive for private-sector Medicare plans to provide the best quality health care to seniors at the most affordable price.

(5) The method by which the national preferred provider organizations in the Federal Employees Health Benefits Program have been reimbursed has proven to be a reliable and successful mechanism for providing Members of Congress and federal employees with excellent health care choices.

(6) Unlike the Medicare payment system, which has had to be changed by Congress every few years, the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most.

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2006 to ensure the long and short term viability of such options for America's seniors.

(3) Develop a payment system for the Medicare Advantage preferred provider organizations similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program.

(4) Limit the addition of new unfunded obligations in the Medicare program so that the long-term solvency of this important program is not further jeopardized.

(5) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(6) Keep the cost of structural changes and new benefits within the $400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(7) Preserve the current employer-sponsored retiree health plans and not design a benefit which has the unintended consequences of supplanting private coverage.

(8) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(9) Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.

AMENDMENT NO. 989, AS MODIFIED

(Purpose: To increase medicare payments for home health services furnished in a rural area)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. ___. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

''(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

''(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

''(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).''.

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S. C. 1395fff(b)(5)) is amended by adding at the end the following:''Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 2003.

AMENDMENT NO. 1126

(Purpose: To provide for the treatment of certain entities for purposes of payments under the medicare program)

At the end of subtitle A of title IV, add the following:

SEC. ___. TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(ww)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act, Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be implemented in a budget neutral manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the total amount of expenditures that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(c) CONSTRUCTION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

AMENDMENT NO. 996

(Purpose: To modify the GAO study of geographic differences in payments for physicians' services relating to the work geographic practice cost index)

In section 445(a) of the bill, strike paragraph (6) and insert the following:

''(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent;

''(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(iii)) to reflect ¼ of the area cost difference in physician work;

''(8) an evaluation of the effect of the adjustment described in paragraph (7) on physician location and retention in higher than average cost-of-living areas, taking into account difference in recruitment costs and retention rates for physicians, including specialists; and

''(9) an evaluation of the appropriateness of the ¼ adjustment for the work geographic practice cost index.''.

AMENDMENT NO. 1118

(Purpose: To express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

AMENDMENT NO. 960

(Purpose: To Require a Streamlining of the Medicare Regulations)

At the end of subtitle A of title V, add the following:

SEC. ___. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'') to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers. If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (B)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its unfeasibility. He shall then establish a feasible reduction to be received by January 1, 2005.

Mr. GRASSLEY. I ask unanimous consent that these amendments and the following pending amendments be adopted en bloc and that the motion to reconsider be laid upon the table: Amendment No. 1017, Allard; No. 968, Harkin; No. 948, Graham of South Carolina; No. 960, Dayton; No. 1054, Feingold; No. 1030, Enzi.

The PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

Mr. GRASSLEY. Thank you. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRAHAM of South Carolina. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

STROM THURMOND

Mr. GRAHAM of South Carolina. Mr. President, I rise to make a brief statement, like my colleague from South Carolina, Senator HOLLINGS, about the passing of Senator Thurmond. This is something I really don't know how to put in words. All of us from South Carolina knew Senator Thurmond in so many ways. But his colleagues in this body, the vast majority of you, have served with him for many years. You have great admiration and fondness for Senator Thurmond but I stand before you as his successor. I often state back home that we change Senators every 50 years and that so many people have been waiting to take Senator Thurmond's place. The jokes just go on and on about what a rich life he has lived.

Tonight his family is mourning his passing. Whether a person lives to be 100 or 200, it is difficult to lose your father. If you lose someone you love, it is always difficult. But when you think about Senator Thurmond, you always have a smile on your face.

He lived a rich life. He lived at times a controversial life. But the biggest testament I can give to Senator Thurmond is that he changed. He changed with the times.

Those of you who embraced him during difficult times your love was much appreciated. Recently people have tried to freeze Senator Thurmond in time which is unfair to him or anyone else. Those who knew him best understood that he changed with the times. And his legacy in my State across party lines, across racial lines, and across regional lines was that he was the go-to guy. If you had a problem with your family or with your business, the first thought in your mind, if the Government was involved, or if somebody was treating you unfairly, was get on the phone and call Senator Thurmond. You would get a phone call back, and he would go to bat for you. Whether you owned the company, or you were the janitor, whether you were black, white, rich or poor, his office and he as a person had a reputation of going to bat for individuals. To me, that is his greatest legacy.

I stand before you as his successor—but not only that, as his friend. He embraced my campaign in 1995. He came to campaign for me when he was 93 years of age. And I was worried to death about if he could make it through the day. Three days later I was glad to see him leave because he about killed me.

He had enthusiasm and passion like no one I have ever met in my life. He did things he didn't have to do. He was a sitting judge in South Carolina in his 40s. He left the judgeship to go volunteer for the Army. He landed in a glider on D-Day, he was shot up, the pilot was killed, and he fought the Germans until they quit, and then he went over to Japan and fought until they quit.

This man, your friend, my friend, South Carolina's favorite son, is gone but he will never be forgotten. His biggest legacy is in the small things he did—not the large things he did. There are so many large things he accomplished. But he lives on in families.